AN ACT relating to health care cost transparency.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

➔SECTION 1. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Allowed amount" means the contractually agreed-upon amount paid by the insurer to a provider participating in the insurer's network or the amount the insurer is required to pay under the terms of the health benefit plan for out-of-network benefits;

(b) "Service" means any nonemergency admission, procedure, or service;

(c) "Program" means the shared-savings incentive program established by an insurer pursuant to this section; and

(d) "Shoppable health care service" means a health care service for which an insurer offers a shared-savings incentive payment under a program, and includes at a minimum health care services in the following categories:

1. Physical and occupational therapy services;

2. Obstetrical and gynecological services;

3. Radiology and imaging services;

4. Laboratory services;

5. Infusion therapy;

6. Inpatient or outpatient surgical procedures;

7. Outpatient nonsurgical diagnostic tests or procedures; and

8. Any other health care services required by the commissioner as promulgated by administrative regulation.

(2) (a) Prior to provision of a service and upon request by the insured to whom the service will be provided:

1. A participating provider shall disclose the allowed amount of the

service, including the amount of any facility fees required; and

2. A nonparticipating provider shall disclose the amount that will be charged for the service, including the amount of any facility fees required.

The disclosure required under this paragraph shall be delivered within two (2) business days of the receipt of the request.

(b) If a provider is unable to quote a specific amount under paragraph (a) of this subsection in advance due to the provider's inability to predict the specific treatment or diagnostic code, the provider shall disclose what is known for the estimated amount for a proposed service, including the amount for any facility fees required. A provider shall disclose the incomplete nature of the estimate and inform the insured to whom the service will be provided of his or her ability to obtain an updated estimate once additional information is determined.

(c) A participating provider shall furnish, upon the insured's request, information regarding the proposed service sufficient enough for the insured to receive a cost estimate from his or her insurer to identify any applicable cost sharing, as defined in KRS 304.17A-172. This estimate may be provided through an applicable toll-free telephone number, Web site, or access to a third-party service that meets the requirements of this section. A provider may assist an insured in using the insurer's toll-free number, Web site, or third-party service.

(3) An insurer shall establish access to an interactive mechanism on its publicly accessible Web site that enables an insured to request and obtain from the insurer, or a designated third-party, information on the payments made by the insurer to participating providers for health care services. The interactive mechanism shall allow an insured seeking information about the cost of a

particular health care service to compare costs among network providers as established in subsection (4) of this section.

(4) (a) Within two (2) business days of the date of an insured's request, an insurer shall provide a good-faith estimate of the allowed amount and any cost-sharing amount for which the insured will be responsible for a proposed service that is a covered benefit from a participating provider based on the information available to the insurer at the time the request is made.

(b) Nothing in this section shall prohibit an insurer from imposing cost-sharing requirements disclosed in the policy or certificate of coverage for unforeseen health care services that arise out of the proposed service or a service that was not included in the original estimate.

(c) An insurer shall disclose to an insured that any amounts provided under this subsection are estimated costs and that the actual costs the insured will be responsible for may vary due to unforeseen services that arise out the proposed service.

(5) (a) An insurer shall develop and implement a program that provides incentives for insureds in a health benefit plan who elect to receive shoppable health care services that are covered by the plan from providers that charge less than the average price paid by that insurer for that shoppable health care service.

(b) Incentives may be calculated as a percentage of the difference in price, as a flat dollar amount, or by some other reasonable methodology approved by the commissioner. The insurer shall provide the incentive as a cash payment to the insured.

(c) The program shall provide an insured with at least fifty percent (50%) of the insurer's saved costs for each service or category of shoppable health care service resulting from the shopping by the insured. An insurer shall not be

required to provide a payment or credit to an insured when the insured's saved cost is fifty dollars ($50) or less.

(d) An insurer shall base the average price for a service on the average paid to a participating provider for the service under the insured's health benefit plan within a reasonable timeframe, not to exceed one (1) year. An insurer may determine an alternate methodology for calculating the average price if approved by the commissioner.

(6) An insurer shall make the program available as a component of all health benefit plans offered by the insurer in this state. Annually, at enrollment or renewal, an insurer shall provide notice about the availability of the program to any insured who is covered by a health benefit plan eligible for the program.

(7) Prior to offering the program to any insured, an insurer shall file a description of the program established by the insurer with the department in a manner prescribed by the commissioner. The department shall review the filing made by the insurer to determine whether the insurer's program complies with the requirements of this section. Filings and any supporting documentation made pursuant to this subsection are confidential until the filing has been reviewed or the waiver request has been granted or denied by the department.

(8) If an insured elects to receive a shoppable health care service from an out-of-network provider that results in a shared-savings incentive payment, an insurer shall apply the amount for the shoppable health care services toward the insured's cost-sharing requirements as specified in the insured's health benefit plan as if the health care services were provided by an in-network provider.

(9) A shared-savings incentive payment made by an insurer in accordance with this section is not an administrative expense of the insurer for rate development or rate filing purposes.

(10) (a) By April 1 of each year, all insurers shall file an annual report with the

department for the most recent calendar year that includes:

1. The total number of incentive payments issued pursuant to this section;

2. The use of shoppable health care services by category of service for which shared-savings incentives are made;

3. The total amount of incentive payments issued to all insureds;

4. The average amount of incentive payments issued by service;

5. The total amount of savings achieved below average prices by service; and

6. The total number and percentage of an insurer's insureds that participated.

(b) By July 1 of each year, the commissioner shall submit a report aggregating the annual reports required under paragraph (a) of this subsection to the Interim Joint Committee on Banking and Insurance.

➔Section 2. This Act takes effect January 1, 2018.